DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED R-C 08/31/2016	
		155343	B. WING				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/	31/2016	
LIFE CARE CENTER OF LAGRANGE				0770 N 075 E			
EII E GARL GENTER OF LAGRANGE				LAGRANGE, IN 46761			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	00) INITIAL COMMENTS		{F 0	000}			
	Paper compliance to complaint IN0020556 2016.	the investigation of 8 completed on July 31,					
	Review Date: Au	igust 31, 2016					
	Facility Number: 000 Provider Number:						
	AIM Number:	155343 100267740					
	compliance with 42 C 410 IAC 16.2-3.1, in I	aGrange was found to be in CFR Part 483, Subpart B and regard to the paper the complaint investigation.					
	Completed by 17934.						
L ABORATORY	I DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 RE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.